

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043401

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 116 Primary Registration District No. 3020 Registrar's No. 266

STATE FILE NUMBER

FILED DEC 4 1963

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON		c. CITY OR TOWN UNION	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. FRANCIS HOSPITAL		d. STREET ADDRESS (If outside, give location) 15 W. SPRINGFIELD	
3. NAME OF DECEASED (Type or print) First MIDDLE Last HERMAN E. ANDREWS		4. DATE OF DEATH Month Day Year DEC. 1 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH AUG. 17, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY JEWELER	11. BIRTHPLACE (City and state or country) BOURBON, MO.
13a. FATHER'S NAME WM. D. ANDREWS		13b. MOTHER'S MAIDEN NAME PEARL LEE GIBSON	14. NAME OF HUSBAND OR WIFE GLADYS ANDREWS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT HOWARD KEY 517 MILL ST.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Concussion, multiple</i> DUE TO (b) <i>lacerations, crushed skull</i> DUE TO (c) <i>laceration of lung contusion head</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 da
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. 3:00 Month, Day, Year 11/28/63		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>Subject drove automobile</i>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Springfield Mo</i>	
21. I attended the deceased from <i>11/28/63</i> to <i>12/1/63</i> and last saw her alive on <i>11/30/63</i>		20f. CITY, TOWN, OR LOCATION Union Franklin MO	
22a. SIGNATURE <i>John J. ...</i>		22b. ADDRESS <i>...</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE DEC. 4, 1963	
24. FUNERAL DIRECTOR OLTMANN FUNERAL HOME		23c. NAME OF CEMETERY OR CREMATORY LESLIE METHODIST CEM.	
25. DATE RECD. BY LOCAL REG. 12/3/63		23d. LOCATION (City, town, or county) (State) LESLIE, MO.	
26. REGISTRAR'S SIGNATURE <i>Leo C. ...</i>			

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

DEC 12 1963

JAN 7 1964

MAR 3 1964

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ralph Olthmann

Licensed Embalmer No. 4808

P. O. Address Union, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.